Handbook for Providers of Therapy Services

Chapter J-200
Policy and Procedures For Therapy Services

Illinois Department of Healthcare and Family Services

CHAPTER J-200

THERAPY SERVICES

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of therapy providers who provide items or services to participants in the department's Medical Programs. It also provides information on which services require prior approval and how to obtain prior approval.

This handbook can be viewed on the department's Web site at

http://www.hfs.illinois.gov/handbooks

This handbook provides information regarding specific policies and procedures relating to therapy services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the department's Web site at

http://www.hfs.illinois.gov/releases/

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

CHAPTER J-200

THERAPY SERVICES

J-200 BASIC PROVISIONS

For consideration for payment by the department for therapy services, a provider enrolled for participation in the department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures http://www.hfs.illinois.gov/handbooks and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the department's paper forms. Providers wishing to submit X12 or NCPDP electronic transactions must refer to Chapter 300, Handbook for Electronic Processing <http://www.hfs.illinois.gov/handbooks>. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

J-201 PROVIDER PARTICIPATION

J-201.1 PARTICIPATION REQUIREMENTS

Therapy services providers must meet one of the following criteria to be considered for enrollment to participate in the departments Medical Programs.

- A Physical Therapist who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice.
- An Occupational Therapist who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice.
- A Speech-Language Pathologist (SLP) who is licensed by the Illinois Department of Financial and Professional Regulation and/or licensed in their state of practice, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for licensure (i.e., individuals in their Clinical Fellowship Year (CFY) with a temporary license).

The provider must be enrolled for the specific category of services for which charges are to be made. The categories of service for which a therapy provider may enroll are:

COS	SERVICE DEFINITION
011	Physical Therapy Services
012	Occupational Therapy Services
013	Speech Therapy/Pathology Services

Please note: Therapists who provide Early Intervention services must be enrolled for Category of Service 041(Medical Equipment /Prosthetic Devices) and Category of Service 048(Medical Supplies). However, these services are not directly billed through Healthcare and Family Services.

Procedure: The provider must complete and submit:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

hfs.PPU@illinois.gov

Providers may also call the unit at 217-782-0538 or mail a request to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
http://www.hfs.illinois.gov/enrollment/

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner, using the prior owner's assigned provider information, may result in recoupment of payments and other sanctions.

J-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix J-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the department files. If any of the information is incorrect, refer to Topic J-201.4.

J-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

J-201.4 PROVIDER FILE MAINTENANCE

The information carried in the department's files for participating providers must be maintained on a current basis. The provider and the department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the department's files. Each time the provider receives a Provider Information Sheet it is

to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change the department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

J-202 REIMBURSEMENT

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payor, a program participant of other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the department bearing charges for those services or items. (Exception: department co-payments are not to be reflected on the claim. Refer to Chapter 100, Topic 114.1 for more information on patient cost-sharing.)

J-202.1 CHARGES

Charges billed to the department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the department after the service has been provided.

A provider may only charge for services he or she personally provides, or for services provided by a licensed therapy assistant under the supervision of the enrolled therapist. Speech-Language Pathologists may also charge for services provided by individuals in their Clinical Fellowship Year. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

J-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

> Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for

providers to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data.

J-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. for specific instructions for preparing claims for Medicare covered services, refer to Appendix J-1a.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix J-1 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

J-202.31 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the department for this purpose, HFS 1444. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use HFS 2248, Special Handling Envelope. A non-routine claim is:

Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.

Any claim to which any other document is attached.

For electronic claims submittal, refer to Topic J-202.2 above. Non-routine claims may not be electronically submitted.

J-202.4 PAYMENT

Payment made by the department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by

the department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

J-202.5 FEE SCHEDULE

A listing of allowable procedure codes by provider type are on the department's Web site. The listing can be found at:

http://www.hfs.illinois.gov/reimbursement/

Paper copies of the listings can be obtained by sending a written request to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
607 East Adams
Springfield, IL 62701

The Web site listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

J-203 COVERED SERVICES

A covered service is a service for which payment can be made by the department. Refer to Chapter 100, Topic 103, for a general list of covered services. A physician's order must be on file and services must be provided in accordance with a definite plan of care established by the therapist or clinical fellow, for the purpose of attaining maximum reduction of a physical disability and/or restoration of the individual to an acceptable functional level. Once the therapist or clinical fellow, has established a plan of care, a licensed therapy assistant under the therapist's supervision may also provide treatment.

> Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

J-203.1 OCCUPATIONAL THERAPY

Covered Occupational Therapy services include medically necessary evaluations and treatment by a licensed Occupational Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Occupational Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when Occupational Therapy services will increase independence and/or decrease the need for other support services.

Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and restoration of the client to an acceptable functional level.

J-203.2 PHYSICAL THERAPY

Covered Physical Therapy services include medically necessary evaluations and treatment by a licensed Physical Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Physical Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when Physical Therapy services will increase independence and/or decrease need for other support services.

J-203.3 SPEECH AND LANGUAGE THERAPY

Speech and Language Therapy are covered services when provided according to established program guidelines and with prior approval as appropriate.

Services must be provided in accordance with a definite plan of care established by the therapist or clinical fellow, for the purpose of attaining maximum reduction of a physical disability and restoration of the client to an acceptable functional level.

J-203.4 THERAPY SERVICES PROVIDED IN A HOSPITAL SETTING

Physical Therapy provided by a salaried therapist in an outpatient setting or hospital-based clinic setting does not require prior approval. Such services will be billed in compliance with the instructions contained in the Hospital Handbook.

Physical Therapy provided by a nonsalaried therapist in an outpatient or hospital-based clinic setting must be in compliance with the instructions contained in this handbook.

Occupational and Speech Therapy services provided by a salaried therapist must be billed in the HFS 1443 under the hospital's name and number. Prior approval may be required depending upon the code(s) utilized when billing.

J-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered by the department's Medical Programs. The objective of the department's Medical Programs is to enable eligible participants to obtain necessary medical care. "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity, or impairment. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

Services provided for the general good and welfare of clients, such as fitness exercises and activities to provide diversion or general motivation, are not covered.

Therapy services are not covered for participants in the Transitional Assistance Program and for adult participants in the Family and Children Assistance Program in the City of Chicago.

J-205 RECORD REQUIREMENTS

The department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

For therapy services, the basic record must include:

- Current physician's order signed by a physician (M.D. or D.O.), advanced practice nurse or physician assistant
- Clinical diagnoses, if not included in the physician's order
- Patient's name, recipient identification number (RIN) and address
- Initial assessment and treatment plan
- Progress reports, and
- Approved prior authorization requests, if applicable.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

J-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, approval must be obtained from the department.

> If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

> Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

Prior approval requirements do not apply in situations in which physical, occupational and speech therapy are provided:

- To an individual within a sixty (60) calendar day period immediately following discharge from an acute care or a rehabilitation hospital;
- To an individual eligible for Medicare Part B benefits and the service is covered by the Medicare Program;
- The individual has been hospitalized within the past thirty (30) days and was, while hospitalized, receiving therapy services;
- To children age 0-20;
- For the initial evaluation and treatment period as described in Appendices J-4 and J-5.

Prior approval is required for continuation of therapy after the initial sixty (60) -day period. It is the responsibility of the provider to initiate the request as soon as possible within the first sixty (60) days in order to avoid disruption of services.

> **Procedure:** The provider is to complete and submit Form HFS 1409, Prior Approval Request. A copy of the physician orders and a copy of the initial evaluation or progress summary are required attachments. The length of time of sessions should be noted.

Prior Approval requirements are waived in instances in which Medicare payment is approved. If the service is noncovered, determined not medically necessary by Medicare, or when Medicare benefits are exhausted, post approval from the department is required.

Procedure: The provider is to submit the adjudicated Medicare billing form, Explanation of Medicare Benefits, and completed Form HFS 1409. Approval will be granted when in the judgement of a consulting physician and/or professional staff of the department; the services are medically necessary and appropriate to meet the individual's medical needs.

J-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

Prior approval requests may be submitted to the department by mail, fax, telephone or electronically via the REV system.

By Mail:

The provider is to complete Form HFS 1409, Prior Approval Request, when requesting covered services. Instructions for its completion are found in Appendices J-2.

All Forms HFS 1409 must be signed in ink by the supplying provider or his or her designee. The Form HFS 1409 must be accompanied by a current signed and dated physician order for the services requested. Submitting the physician order and other necessary information and explanation of medical necessity when the initial request is made will prevent delays in processing prior approvals.

The completed form may be mailed to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, IL 62794-9124

By Fax:

Prior approval may be requested by fax. Complete Form HFS 1409, following the procedures described above for mailed requests. The completed form, the physician order and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt.

The fax number for prior approval requests is 217-524-0099. This fax is available Monday through Friday, 8:30 AM- 5:00 PM, excepting holidays.

By Telephone:

When prior approval is requested by telephone, the request will be data entered by staff at the following telephone number:

1-877-782-5565, select Option 5 from the automated menu.

This number is available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the HFS 1409.

The provider is responsible for having a valid physician order and statement of medical necessity that bears the ordering physician's signature at the time of the request. The department reserves the right to request proof of documentation before approval is granted.

Electronically:

Prior approval requests may be electronically submitted into the department's prior approval system by the provider via any of the department's approved Recipient Eligibility Verification (REV) vendors. For more information on the REV system, refer to Chapter 100, Topic 131.2. For a listing of approved REV vendors, refer to http://www.hfs.illinois.gov/rev/

If the provider is mailing or faxing the physician order or other medical documentation in support of an electronically submitted request, this information should be noted in the comments section of the electronic request. In addition, the mailed or faxed materials should clearly indicate that the prior approval request has been electronically submitted. Failure to make these notations will make it more difficult for the department to match the documentation with the prior approval request and thus may delay a decision on the request.

The department reserves the right to request proof of a valid physician order or other supporting documentation before approval is granted.

J-211.2 APPROVAL OF SERVICE

If the service requested is approved, the provider and the patient will receive a computer-generated letter, Form HFS 3076A, Prior Approval Notification, listing the approved services. Upon receipt of the Prior Approval Notification, the service(s) may be billed.

Any changes/corrections needed to the prior approval notification HFS 3076A, must be submitted as a review via mail or fax with supporting documentation to the prior approval unit.

J-211.3 DENIAL OF SERVICE

If the service requested is denied, a computer-generated Form HFS 3076C, citing the denial reason, will be sent to the patient and the provider. The provider cannot file an appeal of the denial. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

J-211.4 TIMELINES

The department is obligated to make a decision on prior approval requests within specified time frames. In general, decisions must be made within twenty-one (21) days of receipt of a properly completed request, with exceptions as described below. If no decision has been made within the twenty-one (21) -day period, the service is automatically approved. If a service has been automatically approved, reimbursement will be made at the provider's charge or the department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the department may request additional information from either the supplying provider or the physician who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the twenty-one (21) -day period stops. When the required information is received, a new twenty-one (21) -day period begins.

The provider can request status of a prior approval after thirty (30) days from the department's receipt date. This can be done via mail, fax or by calling the prior approval unit at 1-877-782-5565 Option 5.

J-211.5 POST APPROVALS

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for All Kids was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than ninety (90) days following the departments Notice of Decision approving the patient's application.
- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To

be considered under this exception, documentation that the provider billed a third party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than ninety (90) days from the date of final adjudication by the third party.

- The patient did not inform the provider of his or her eligibility for Medical Assistance or All Kids. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval must be met and post approval requests must be received by the department no later than ninety (90) days from the date services or items are provided or within the time frames identified above.